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ABSTRACT

Drug addicted and non-addicted parents show similar behaviors and attitudes toward their children; however, addicted women are more likely to feel inadequate in their role as mothers. The results of two studies comparing the relationships between drug addicted and non-drug addicted parents and children of addicts and non-addicts showed little differences in the childrearing techniques and disciplinary measures of addicted and non-addicted parents; addicted mothers were more likely to use verbal punishment. Young children of addicted parents tended to score lower on intelligence tests; school-age children with addicted parents tended to have more school adjustment and behavior problems. Findings suggest that children from multi-problem homes may benefit from services available in drug treatment programs. (JAC)

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National Institute on Drug Abuse

SERVICES RESEARCH REPORT

HEROIN-ADDICTED PARENTS AND THEIR CHILDREN

TWO REPORTS

CG 015431

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The Services Research Reports and Monograph Series are issued by the Services Research Branch, Division of Resource Development, National Institute on Drug Abuse. Their primary purpose is to provide reports to the drug abuse treatment community on the service delivery and policy-oriented findings from Branch-sponsored studies. These will include state-of-the-art studies, innovative service delivery models for different client populations, innovative treatment management and financing techniques, and treatment outcome studies.

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Preface

In recognition of the lack of data on the children of addicts, there has recently been an increased effort to study the impact of the heroin addiction of parents on their children. The few studies that do exist have been somewhat limited in scope. Typically, they have focused solely on the short-term effects of addiction during pregnancy or have lacked adequate comparison groups. The two studies summarized in this document attempted, in different ways, to proceed beyond these limitations.

In her study titled "A Comparison of Heroin-Addicted and Nonaddicted Mothers: Their Attitudes, Beliefs, and Parenting Experiences," Dr. Colten draws upon data obtained in a larger study of the psychosocial characteristics of heroin-addicted women. Her report focuses on the significance of the mothering role to opiate-addicted women, and of the parenting practices of those women as compared to their nondrug-using peers.

Drs. Sowder and Burt, in their paper, "Children of Addicts and Nonaddicts: A Comparative Investigation in Five Urban Sites," are also concerned with clarifying the relationship between addicted parents and their older (3 to 18 years) offspring. Whereas Dr. Colten's study centers primarily on the mother and her behavior, Dr. Sowder's work emphasizes the child and the child's functioning. Dr. Sowder's investigation was conducted to determine whether 3- to 18-year-old children living with heroin-dependent parents are at greater risk for health, learning, behavioral, socioemotional, and/or adjustment problems than 3- to 18-year-old children living with comparable nonaddicted parents.

The two reports provide us with significant and clinically useful information about these family units in terms of their structure, the relationships within them, and the behaviors and functioning of family members. The studies are rich in their implications for service delivery on behalf of the families of drug abuse clients.

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A Comparison of Heroin-Addicted and Nonaddicted Mothers

Their Attitudes, Beliefs, and Parenting Experiences

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Abstract

A study of addicted and nonaddicted mothers found that the two groups show similar behaviors and attitudes toward their children, but that addicted women are more likely to feel inadequate in their roles as mothers. The investigation involved comparison of data drawn from the interviews of 170 female addict-clients in 3 cities and from interviews of 175 nonaddicted women who were located through the unemployment office in 1 of those cities. Respondents were queried regarding attitudes toward childrearing, expectations for their children, disciplinary activities, children's behaviors, concern about childrearing, and community supports for childrearing efforts.

The addicted women were significantly less likely to have their children living with them. Only 49 percent of the addicted mothers had all their children living with them, while 88 percent of the nonaddicted mothers had all their children at home. Nine percent of the addicted mothers had some, but not all, of their children living with them. Some of the separation may be due to the fact that 36 percent of the addicted women in the sample were living in therapeutic communities.

Addicted and nonaddicted women did not differ in their views of the ways in which having a child changes a woman's life or in their notions of the most positive and negative aspects of having children. Addicted mothers expressed greater concern about certain negative outcomes for their children. They were more likely to think about their children becoming drug addicts, going to jail, and dropping out of school than were nonaddicted mothers. However, there were no differences between the groups in the extent to which they worried about other problems such as alcoholism, and they invested similar amounts of time in thinking about positive future outcomes.

Addicted and nonaddicted mothers did differ significantly in the disciplinary measures they used. In comparison to nonaddicted mothers, addicted mothers were more likely to use verbal punishment and less likely to use physical punishment. The groups were equally likely to restrict a child's activity or to assign extra duties as punishment.

A significant minority of addicted mothers (20 percent of addicted mothers as compared to none of the nonaddicted mothers) perceived themselves as less adequate, as "poorer than most mothers." By comparison, 51 percent of the nonaddicted mothers but only 32 percent of the addicted mothers perceived themselves as "better than most mothers."

Children are very important to women in both groups. Ninety-six percent of both addicted and nonaddicted mothers reported that they enjoyed being a mother "as much" or "more than" most mothers. Moreover, 55 percent of the addicted women and 61 percent of the nonaddicted women reported that their children were the most important parts of their lives. The vast majorities of both addicted women and nonaddicted women reported that they got along very well with their children (81 percent of addicted and 83 percent of nonaddicted women).

A significant minority of addicted mothers (42 percent) reported themselves as able to discuss childrearing problems with their mothers, and 22 percent had discussed some aspect of the child's health in the month immediately preceding interview. In general, nonaddicted mothers reported a greater availability of the child's father as a resource, while addicted mothers were far more likely to call on their own mothers. Only 15 percent of the addicted mothers reported that they were able to use the drug abuse treatment program as a place in which to discuss childrearing problems.

The data suggest, then, that addicted and nonaddicted women differ little in childrearing practices, although a substantial minority of addicted mothers expressed a greater concern about their own ability to fulfill the mothering role. Given the importance of the mothering role to these clients and the fact that the treatment program is not currently seen as a significant resource, it would appear appropriate for programs to undertake those activities that would assist clients with their childrearing concerns and/or to develop referral strategies for selected childrearing issues.

INTRODUCTION

The role of mother is central to almost every woman who holds it. Mothering and the relationship between mother and child are sources of self-definition, gratification, stress, constraint, responsibility, and reward. In any consideration of the psychosocial characteristics, life situations, and therapeutic treatment for any group of adult women, their functioning as mothers and their relationships with their children should be primary foci.

Although the majority of heroin-addicted women are mothers, scant attention has been paid to the meaning of that role for them, and even less attention has been given to the role of motherhood in the treatment process. When the relationship between heroin addiction and mothering is noted, it is generally done with a focus on the well-being of future generations, with particular emphasis on the physiological effects of opiates and opiate substitutes on fetuses and neonates. Entire conferences and monographs on the addicted mother and her family have appeared with barely a mention of the mother. She is viewed as an independent variable--as the source and never the victim of the problem--and is seen only in the most negative terms.

While it is undeniable that being conceived by, carried by, and born to a woman who uses heroin or methadone may have serious physical consequences for a child and, at best, places an infant temporarily at a physical disadvantage (Blinick et al. 1973; Dickey and Hall 1978; Finnegan et al. 1972; Ramer and Lodge 1975; Reschner and Brotman 1977), the psychosocial implications for both mother and child are much less clear. We know almost nothing of the lives of those children beyond the infant or toddler stages and/or their relationships with their addicted mothers.

Once born, the "worst" may be over for the child. However, there are those who allege that an addicted woman cannot be a good or even an adequate mother. Densen-Gerber and Rohrs (1973) state that "Addiction must be designated as a prima facie criterion of unfitness as a parent." They note that the dynamics of continued drug use during pregnancy exemplify a lack of concern for the well-being of the child. They conclude that addicts "are incapable of acting in the best interests of their child or meeting a child's needs."

Eldred et al. (1974) point out that children of addicts have been viewed from two perspectives. The first is as a force in their parents' lives--as stressors and as motivators of change. The second is as a focus of concern themselves, without regard to the parents. This second perspective dominates the literature, limited though it may be. We do not know the extent to which this perspective plays a role in programs for pregnant addicts; few treatment programs even incorporate facilities for daycare into their design (Harris 1975). Eldred et al. note that parents and their children could be better viewed as parts of a single interaction process and that it is possible to have integrated treatment that addresses the needs of both the parent and the child since those needs are not necessarily in conflict with one another.

Several issues have clouded most previous investigations or discussions of the parenting behavior of heroin addicts. As mentioned before, studies have focused solely on the negative short-term effects of addiction during pregnancy. Others have lacked adequate and appropriate comparison groups; the effects of poverty and deprivation are often confounded with the impact of addiction on the parent's ability to function. It is sometimes acknowledged (Stryker 1977) that the deficits of addicted mothers are that they lack the material resources and social supports for successful parenting--a more remediable problem than the personality or character deficits ascribed to addicted parents by other writers. The failure of studies to control for material resources is often accompanied by a middle-class stance on what constitutes proper and good parental behavior.

Another problem derives from the a priori assumptions that addicted parents are child neglectors at best and child abusers at worst, and that addicted parents and their children are isolated from the involvement and input of other caring adults. Both of these assumptions need to be examined.

This paper draws upon data from a psychosocial study of heroin-addicted women, addressing some of the issues and debates about heroin-addicted mothers. In this report, comparison will be made between a sample of addicted women and a sample of nonaddicted women.

The questions asked of the respondents about mothering attitudes and experiences were designed with several goals in mind. The first was to provide a general picture of the mothering experience of addicted women and to determine whether their attitudes and experiences differed from those of nonaddicted women from similar socioeconomic circumstances. Since the number and variety of questions one could ask women about parenting seem virtually limitless, questions (in addition to those intended to provide this general picture) were selected in order to further examine themes that predominate in the literature on substance-abusing women and their children. The study also examined the social supports addicted women have in their childrearing endeavors--who helps them out, who advises them, who can be trusted to care for the child. Finally, whether use of heroin preceded or followed the birth of the first child was explored.

METHOD

Respondents were 170 females in treatment for heroin addiction in Detroit, Los Angeles, and Miami, and a comparison sample of 175 nonaddicted women from Detroit. Overall, the Detroit addicted women and the addicted women from other cities did not differ from each other on the demographic variables (e.g., age of children, marital status, and education) that distinguish the Detroit addicted women from the Detroit comparison group. It was therefore considered to be appropriate to compare nonaddicted mothers from Detroit to addicted mothers from all three cities (Colten et al. 1979). Prior study indicated that differences between the Detroit samples (addict/nonaddict) were maintained when the additional addicted samples were compared to the Detroit nonaddict sample.

The addicted respondents were obtained through umbrella drug treatment agencies, each of which had responsibility for a number of treatment programs including methadone maintenance centers and therapeutic communities. Client participation in the study was voluntary and respondents were paid at completion of the interview. The comparison respondents were recruited through a branch office of the Michigan Employment Security Commission located in the same neighborhood as several of the participating treatment centers. All women seeking assistance from the office during a 4-month period were asked to participate in the study. Comparison respondents were also paid at the completion of the interview.

All of the heroin-addicted respondents were in heroin abuse treatment programs at the time of interview. They had entered the program within 3 weeks of the time of interview. Of these women, 63.7 percent were in methadone maintenance programs and 36.3 percent in therapeutic communities. It is important to note that the study reports on the attitudes, beliefs, and behaviors of addicted women involved in treatment. As such, it does not pretend to be representative of the larger body of addicted women in the community. It would seem likely that one's role and status as a drug abuse client has an impact on ideas about self, the community, and one's relationship to that community. Thus, the study intentionally reflects the concerns and ideas of the addicted woman and, more pointedly, of the addicted mother in the treatment setting.

The addicted and comparison (nonaddicted) women do not differ in age, race, or employment status. However, the comparison women

have completed more years of school, on the average having finished high school. A more complete description of the sample is provided in Addicted Women: Family Dynamics, Self Perceptions, and Support Systems (Colten et al. 1979).

All respondents were given structured face-to-face personal interviews lasting 2 to 3 hours by trained female interviewers. The interviews covered a broad spectrum of areas, including self-perceptions and attitudes, social supports, social histories, drug-use histories, problems, parenting attitudes and experiences, and demographic characteristics.

RESULTS

Seventy percent of the addicted women in the study have children, compared to only 49.7 percent of the nonaddicted women (χ^2 (1) = 14.75; $p < 0.001$). A look at table 1 shows, however, that for those women who had children, there was not a significant difference (at 0.05 confidence level) between the addicted and the nonaddicted samples in the number of children, in the age of the oldest child, and in the age of the youngest child. There is a trend (t (204) = 1.81; $p < 0.08$) for the oldest child of the addicted mothers to be older than the oldest child of the nonaddicted mothers, implying a significant difference between the two groups in the mean age of the mothers when their first child was born (t (204) = 4.43; $p < 0.001$). In this regard, Binion (1978) has noted that the addicted women in this study were more likely than the nonaddicted women to have dropped out of school because of pregnancy.

We next turn to the relationship between marital status and parental status. More of the nonaddicted women were presently married (27.4 percent versus 15.9 percent) or never married (53.7 percent versus 45.3 percent), while more of the addicted women (38.3 percent) than the nonaddicted women (18.9 percent) had been previously married--divorced, widowed, or separated. Addicted and nonaddicted women without children showed similar marital status distributions. However, table 2 illustrates a striking (χ^2 (2) = 23.23; $p < 0.001$) difference between the nonaddicted and addicted mothers. While 46 percent of the nonaddicted mothers were presently married, this was true for just 16.8 percent of the addicted mothers. Twice as many addicted mothers (49.6 percent) as nonaddicted mothers 24.1 percent) had been previously married. Also important to note is that approximately equal percentages of the nonaddicted and addicted mothers in this sample had never

TABLE 1. --Number and ages of children

Characteristic	Nonaddicted N (average)	Addicted N (average)	t	p
Number of children				
M	1.98	2.07	0.47	NS
SD	1.08	1.51		
N	(85)	(119)		
Age of oldest child (years)				
M	6.86	8.29	1.81	NS
SD	5.6	5.53		
N	(87)	(119)		
Age of youngest child (years)				
M	4.67	5.31	1.09	NS
SD	4.39	4.06		
N	(87)	(119)		
Age of respondent at birth of first child (years)				
M	20.72	18.45	4.43	< 0.001
SD	4.49	2.88		
N	(87)	(119)		

TABLE 2.--Marital status of mothers (in percent)

Marital status	Nonaddicted (N=87)	Addicted (N=119)
Married	46	16.8
Previously married	24.1	49.6
Never married	29.9	33.6
$\chi^2 = 23.28$; $p < 0.001$		

been married. So, we view the addicted mothers as having been party to terminated marriages more often than nonaddicted mothers, but as no more likely to have never been married.

The sample was then stratified according to whether or not the mothers had children currently living with them--children who would be expected to be in need of adult supervision. Therefore, children who had left home because they were grown up or were away at college (both of these categories were predictably quite small in this sample) were not considered in this categorization. Of the addicted mothers, 48.7 percent had all of their children living with them, 42 percent had none of their children living with them, and 9.3 percent had some, but not all, of their children living in the same household with them. Over 88 percent of the nonaddicted mothers, however, had all of their children living with them. This constitutes a significant difference between the groups (χ^2 (2) = 37.68; $p < 0.0001$). It is interesting to note that nonaddicted mothers having all of their children at home were the most likely of the nonaddicted group to be married, but this did not hold for addicted mothers (table 3). An addicted mother appears to be least likely to have any children living with her if she has been previously married--a loss of both the parental and spousal roles.

From table 4 we see that 97.7 percent of the children of the nonaddicted mothers lived with them, while this could be said for only 56.3 percent of the children of the addicted mothers. It should be remembered that, at the time of the interview, over 36 percent of the addicted sample were residing in therapeutic communities, not all of which were receptive to children or organized to accommodate them. Where, then, did the children of the addicted women live?

Contrary to what has been popularly assumed, only 10.9 percent of these children were in institutions, foster care, or in adoptive homes. The remainder not living with their mothers (minus the 6.7 percent who were grown) lived with other family members--20.2 percent with the respondent's mother, 17.6 percent with other relatives of the respondent, including in-laws and former in-laws, and 11 percent with the child's father. In other words, fully

TABLE 3.--Addicted mother's marital status and number of children in her home (in percent)

Marital status	Addicted respondent's children at home		
	All	None	Some
Married	17.2	14	27.3
Previously married	39.7	62	45.5
Never married	43.1	24	27.3
N	(58)	(50)	(11)

TABLE 4. --Settings in which children are living (in percent)

Where child lives	Nonaddicted	Addicted
With respondent	97.7	56.3
With child's father	3.5	11
Grown	5.8	6.7
With respondent's mother	1.2	20.2
With other relative	0	17.6
Institution or foster care	0	10.9

Note: Columns total more than 100 percent because some respondents have more than one child.

one-fifth of the children of the addicted mothers in this sample lived with their maternal grandmothers, and nearly that many lived with other relatives. This illustrates forcefully the involvement of the families as supports for these children, and possibly for their mothers, too. Even if an addicted woman is abandoned by her family (and we have no evidence that this happens), her children most certainly are not. When asked why the children were living elsewhere, the majority of the addicted mothers reported that it was for the well-being of the child. Unfortunately, our respondents were not asked if they felt coerced into relinquishing the child into the care of the family members or if it was done as a matter of choice.

Attitudes Toward Children

We turn now to attitudes of the addicted and nonaddicted women toward children. The respondents were asked how having a child changes a woman's life, and the nicest and the worst things about having children. These questions were asked of all respondents, so the results are reported for the whole group, including both mothers and nonmothers. Unless otherwise noted, separate analyses for mothers and nonmothers did not produce results that differed from those of the total group. The responses of the women to these questions are shown in tables 5, 6, and 7. What is most striking about these results is the lack of significant differences between the addicted and nonaddicted women.

TABLE 5.--Reports of life changes created by children (in percent)

Type of change	Nonaddicted	Addicted
General positive	6.4	13
Affiliative	4.1	5.3
Influence	1.2	0.6
Achievement	2.3	3
Other satisfaction	6.4	5.9
Positive change in self	24	29
Neutral change in self	66.7	68.6
Negative change	29.2	21.3

Note: More than one response was allowed, so percentages do not total 100 percent.

TABLE 6. --Reports of positive impacts of having children (in percent)

Category endorsed	Nonaddicted	Addicted
General	40.5	43.7
Affiliative satisfaction	48.8	56.3
Influence	17.3	10.8
Achievement	11.9	10.2
Other satisfaction	13.1	12
Positive change in self	1.8	2.4
Negative change in self	2.4	0.6
Other	2.4	0.6

Note: Columns do not total 100 percent because more than one response was allowed.

TABLE 7. --Reports of negative impacts of having children (in percent)

Category endorsed	Nonaddicted	Addicted
Nothing	8.7	3.6
Practical	15.7	12
Birth process	16.9	16.9
Worry/inadequacy	29.7	28.3
Stress	16.9	18.1
Restrictiveness	19.2	21.7
Bad world for kids	4.1	3.6
Not wanting	6.4	5.4
Kids disappoint you	2.3	1.2

Note: Columns do not total 100 percent because more than one response was allowed.

It has often been postulated that addicted women have unrealistic expectations about the effects of having children and the qualities to be anticipated in the relationship with the child (e.g., Densen-Gerber and Rohrs 1973). The data in this study do not support this assumption; the addicted women in this sample appeared to be no more unrealistic about the impact of having children than were their nonaddicted counterparts.

In an effort to approach the same issues in a slightly different manner, the respondents were all given a list of reasons for having and for not having children and were asked to indicate if the reason given was a good one. Comparisons between the addicted and nonaddicted samples in their endorsement of reasons given as being good are displayed in table 8, and comparisons between the two groups in their endorsement of reasons for having children given as being bad are displayed in table 9.

There is only one significant difference between the groups in their endorsement of good reasons for having children: The nonaddicted women were more likely to say that a good reason to reproduce is to have a child to help around the house. The groups do not differ in the extent to which they believed that having someone to love or to need you is a good reason for having a child. The addicted women were also no more likely to expect that children would be fun, a joy to have around, or a balm in one's old age.

A look at table 9 reveals that addicted women are likely to have concerns about their adequacy as mothers. Our addicted women were overwhelmingly more likely to say that "Because you would not be able to give enough

TABLE 8.--Reasons endorsed as proper for having children (in percent)

Reason for having children	Nonaddicted	Addicted
a. To have someone to love and care for	81.7	92.3
b. To have a child to help around the house[1]	31	[2]20.8
c. Because of the joy you get out of watching a child grow	98.3	98.2
d. To be like other women you know	9.1	11.9
e. To feel needed and useful	68.6	71.4
f. Because a new baby means a change--something new	48.6	53.6
g. Because you think you could be a good mother	87.9	85.1
h. To help carry on your family name	32.4	29.3
i. Because women are supposed to have children	11.6	13.7
j. To be sure that in your old age you will have someone to help you	24	15
k. Because it would be fun to have a child around the house	76.3	69.5
l. Because it makes the father feel like more of a man	35.6	36.3
m. Because the father wants children	69.4	65.5
n. Because you can't help having children	8	9

[1]Addicted and nonaddicted groups differed significantly.
[2]χ^2 (1) = 4.62; $p < 0.05$ (N=174;168).

care and attention to the child" and somewhat more likely to say that "Because you think you'd make a bad mother" are good reasons for not having children. Fears about adequacy are salient for addicted mothers.

Interestingly, it was the nonaddicted women who were significantly more likely to say that a good reason not to have children is because they take too much time and energy. Since the groups were equally likely to endorse other items concerning costs, burdens, and constraints on freedom, privacy, and other relationships, the time investment may be a more critical issue for nonaddicted women. However, the numbers endorsing this item were not very high for either group, so there is the risk of overinterpreting this finding.

A theme pervading the literature is that addicted women tend to imbue the idea of having children with fantasies about how a child will love the mother unequivocally and will provide a limitless supply of companionship and adoration that will offer the woman (and others) evidence of her value as a person. These notions are obviously not supported by these data. Further evidence is provided by our finding that there was no significant difference between childless addicted and nonaddicted women in whether or not they would like to have children--85.2 percent of the nonaddicted childless women and 82 percent of the addicted childless women said that they would like to have children. Similarly, there was no significant difference between nonaddicted and addicted mothers in their responses

TABLE 9.--Reasons endorsed as proper for not having children (in percent)

Reason for not having children	Nonaddicted	Addicted
a. Because it costs too much to raise children these days	55.4	57.5
b. Because you would not be as free to do what you want to do	53.7	56.5
c. Because they might turn out badly because you didn't do a good job	31	36.5
d. Because they might turn out badly without it being your fault	33.1	29.2
e. Because you would not be able to give enough care and attention to the child	51.3	[2]81
f. Because of the worries children cause when they're sick	12	9.5
g. Because they take up too much of your time and energy[1]	29.7	[3]17.4
h. Because you lose your privacy	19.4	13.7
i. Because they come between you and your lover	16.7	13.7
j. Because the world is a mess so why bring them into it	35.1	42.3
k. Because they're too much of a burden	21.1	16.7
l. Because they make you feel old	7.5	4.2
m. Because you think you'd make a bad mother	47.4	[4]58.9
n. Because your man doesn't want children	50.9	45.2

[1]Addicted and nonaddicted groups differed significantly.
[2]χ^2 (1) = 20.73; $\underline{p} < 0.001$ ($\underline{N}$=175;168).
[3]χ^2 (1) = 7.21; $\underline{p} < 0.01$ ($\underline{N}$=175;167).
[4]χ^2 (1) = 4.55; $\underline{p} < 0.05$ ($\underline{N}$=175;168).

to being asked if they would like to have more children--49.4 percent of the nonaddicted mothers and 59.7 percent of the addicted mothers responded affirmatively.

We should note here that addicted and nonaddicted respondents did not differ in their attitudes toward birth control. However, almost one-third of both the addicted (27.9 percent) and the nonaddicted (32.7 percent) women said they were "very against" or "somewhat against" birth control.

Before turning to actual mothering experiences, there is one more question concerning beliefs about children that was asked of all respondents and that may well offer some important insights about the mothering experience of addicted women. The women were asked which of the following opinions they agreed with most:

(a) Parents have the most control over the kind of adults their children turn out to be.

(b) Parents have only some control over how their children turn out. The outside world or the "street" also has a lot to do with it.

(c) Parents have no control over how their children turn out. It's all the result of the outside world or the "street."

There were differences between the groups in their choices between these alternatives. The addicted women were more likely (9.6 percent versus 4 percent) to feel that the outside world or the "street"--forces other than themselves--have the greatest influence over how their children turn out. It may well be that this response pattern reflects the actual experience of these women while they were growing up; their parents may have had little influence over them. It may also reflect some regrets--if their parents had had greater control, the "streets" might not have led them to heroin. This result fits into the pattern of fear of inadequacy, inability, and lack of control in childrearing that permeated the responses of the addicted women. It should be noted, however, that less than 10 percent of the addicted mothers felt they had virtually no control over their children's future. However, half as many addicts as nonaddicts (10.8 percent versus 21.1 percent) felt that parents have the most control over how children turn out. This result is consistent with the other responses of the addicted women. The data to be presented next demonstrate that these fears were not necessarily supported by the kind or quality of the relationships addicted women had with their children.

Mothering Experiences

There were no major differences between the descriptions that the nonaddicted and the addicted mothers gave of their children. The groups were almost equally likely to say that their children liked to be kissed and hugged (87.7 percent of nonaddicted mothers versus 94.5 percent of addicted mothers), were unanimously proud of their children (100 percent of both groups), and were equally likely to say that their children reminded them of themselves when they were children (58.5 percent of nonaddicted and 59.7 percent of addicted mothers).

The two groups expressed similar feelings about their children and their relationships with them. Approximately the same percentages of each group reported that their feelings about their children sometimes underwent sudden changes.

The addicted and nonaddicted mothers did not differ in their reports of how often their children misbehaved or in the number of problems they felt they had with their children--13.6 percent of the nonaddicted mothers and 12.2 percent of the addicted mothers reported that their children misbehaved most of the time. Only 4.8 percent of the nonaddicted mothers felt that their children had a lot of problems. In fact, the majority of the women in both groups (83.3 percent of nonaddicted and 81 percent of addicted) reported that they got along with their children very well.

Significantly, 54.5 percent of the addicted women, compared to 60.5 percent of the nonaddicted women, reported that their children were the most important things in their lives. The importance and the enjoyment of the mother role were very similar for the groups. Compared with other women, addicted mothers don't appear to either overvalue or undervalue the role. More than 96 percent of both groups reported that they enjoyed being a mother "as much" or "more than" most mothers.

A look at reports of some additional behaviors reveals a few more differences, although many similarities, between the groups. Sunday school or church attendance does not differ significantly between the children of the nonaddicted and addicted mothers. It was reported that 78.4 percent of the addicted women's children attended Sunday school or church, compared to 77.4 percent for the children of nonaddicted women. The children were not reported to differ in whether or not they had special chores around the house (84.1 percent of the nonaddicted versus 77.3 percent of the addicted group). There are

also no discernible differences between the responses of the nonaddicted and the addicted mothers in how they spent time with their children and in the kinds of special things they did with and for their children.

Children of both the addicted and the nonaddicted mothers did seem to get money in slightly different ways. While the responses "ask adults for it" and "work outside the home" were mentioned with similar frequency by both groups, the children of the addicted mothers were reported to get an allowance--contingent or not contingent on doing work--more often than were the children of the nonaddicted mothers (53.9 percent and 25 percent, respectively).

There was no significant difference between the addicted and nonaddicted mothers in the response to the question "How often are you able to get your child to mind you without a hassle or a lot of trouble?" More than 91 percent of both groups reported it as a hassle "sometimes" or "most of the time." This is consistent with the previously reported lack of difference between the groups in the number of problems they had with their children and in the frequency with which their children misbehaved. However, there is a difference between the groups in how strict they perceived themselves as being with their children and in the modes of punishment they reported using.

Addicted mothers reported themselves as being significantly less strict than nonaddicted mothers: 46.8 percent reported that they were "not very" or "not at all" strict, compared to 27.7 percent of the nonaddicted mothers. As can be seen from table 10, addicted mothers were significantly less likely to give spankings or whippings (χ^2 (1) = 11.93; $p < 0.001$) and significantly more likely to say they gave lectures to the child on wrongdoing.

Because addicted women are so often alleged to be child abusers, these findings should be carefully noted and examined in light of the other available evidence. An objection that might be raised to counter these findings is that the addicted mothers were giving a "socially desirable" response, that in fact they did beat their children but just wouldn't admit it. While this is possible, the other data do not offer any evidence to support it. First, almost half of the addicted women reported that they spanked their children. Second, other modes of punishment were reported with equal frequency by the two groups. About one-fifth of the addicted mothers said that they screamed and yelled at their children--certainly not a "socially desirable" approach to discipline. Sixty percent of the addicted women and 52 percent of the nonaddicted women reported that they told their children that they were going to punish them, but did not get around to doing it. This may be seen as inconsistency--a less than proper childrearing technique but one that is acknowledged by the majority of women in both groups.

Others have reported that addicted women suffered greater personal trauma from their families in their formative years (Aron 1975; Benward and Densen-Gerber 1975). Binion (1978) has shown that the families of the addicted women in this sample used a greater

TABLE 10.--Use of different kinds of punishment (in percent)

Kinds of punishment	Nonaddicted (N=77)	Addicted (N=105)	χ^2	p
Give spankings or whippings	74	48.6	11.93	< 0.001
Make do extra work	3.9	8.6	1.57	NS
Give lectures on what did wrong	16.9	42.9	13.8	< 0.001
Don't let go some place or do something	48.1	45.7	0.08	NS
Scream and yell at them	10.4	19	2.56	NS
Make go to room or corner to be alone	33.8	31.4	0.11	NS

Note: Each item was asked individually; respondent could report "yes" to several kinds of punishment.

number of different kinds of punishment than did the families of the nonaddicted women. The addicted mothers may well have been contrasting their ways of disciplining their children with their own experiences of being disciplined. By the standards of their own childhoods, they may have seen themselves as being less strict and may have shied away from the physical punishment that raised unpleasant memories.

Several investigators (for instance, Korsch et al. 1965; Stark and McEvoy 1970) have reported that physical punishment is used more frequently when children are young. The children of the addicted women in this sample tended to be older than those of the nonaddicted women. This age difference could well have contributed to the difference in use of physical punishment reported by the two groups. Also, addicted mothers may have used less physical punishment because they were less optimistic about its effect. Recall that addicted women felt that they had less control over how their children would turn out.

Table 11 displays expectations about the future. Addicted mothers, significantly more than nonaddicted mothers, reported that they worried about their children dropping out of school, winding up in jail, and becoming drug addicts. These concerns are logical in light of their own experiences. They did, however, think about positive things happening to their children as often as the nonaddicted mothers and did not worry with greater frequency than the nonaddicted mothers about their children having unhappy lives or becoming alcoholics.

Lack of control and feelings of inadequacy are recurring themes for addicted mothers. As mentioned earlier, these feelings are reinforced and possibly inculcated by the responses of others to addicted mothers. Even those who "take care of" and provide treatment for addicted women expect that they cannot possibly be good mothers or care adequately for their children. Colten (1978) has reported that the low self-esteem felt by addicted women is an apparent reflection of the attitudes that people hold toward addicted women. Data show that this deflated opinion of self extends to the mother role. Significantly more (19.8 percent versus 0 percent) of the addicted mothers said they were performing "poorer than most mothers" and many fewer of them (31.5 percent versus 51.2 percent) said they were doing better than most mothers ($\chi^2(2) = 21.7$; $p < 0.00001$). Since the mothering role and their children were as important to them as they were to nonaddicted mothers--over half stating that their children were the most important things in their lives and nearly all stating that they enjoyed being mothers--this felt lack of adequacy as a mother must be devastating. The centrality of the mothering role and its importance for a sense of self should be carefully considered.

Supports for Childrearing

Tucker (1978) has noted that certain critical relationships may be absent from the social network of addicted women and that although they are not isolates, they tend to be more isolated than nonaddicted women. We might expect, then, that some of their concerns about being able to fulfill the mothering role may be associated with their lack of ties to others who might help them with their children and who might also form ties with their children.

From the results presented in table 12 it can be seen that addicted mothers reported having just as much help with their children as did the nonaddicted women. Even if they lacked support for themselves, it was not lacking for their children. Table 13 shows that their mothers were mentioned more frequently by the addicted women as the persons who could be trusted to care for their children. The percent difference between the addicted women and the nonaddicted women in mentioning the mother is almost equal to the difference between the addicted and nonaddicted groups in mentions of the child's father or the woman's partner. This follows from the fact that more of the nonaddicted mothers were presently married. When a partner was not available, mother appeared to fill the gap. (Or it also may be that when mother was unavailable, the partner was more willing to help.) Of those respondents who had experienced some worry about the health of their children in the previous month, 22 percent of the addicted mothers versus 3.8 percent of the nonaddicted mothers discussed the problem with their own mothers (χ^2 (1) = 4.24; $p < 0.05$). However, there was not a significant difference between the groups in the use of a doctor or clinic, indicating that addicted women do not use the advice of their mothers in place of appropriate formal helping sources.

Addicted women were also more likely than nonaddicted women to have talked with their mothers if they had had a childrearing problem in the previous month; 41.7 percent of the addicted mothers compared with 9.5 percent of the nonaddicted mothers mentioned their own mothers as persons with whom they talked about a childrearing problem (χ^2 (1) = 6.55;

TABLE 11.--Anticipations about future of children (in percent)

Thoughts about children	Group	Frequency of thinking about this happening				N	χ^2	p
		Never	Hardly ever	Sometimes	Often			
They'll have unhappy lives	Nonaddicted	31.4	33.7	25.6	9.3	86	5.31	NS
	Addicted	32.5	20.2	34.2	13.2	114		
They'll become alcoholics	Nonaddicted	69.8	16.3	11.6	2.3	86	0.81	NS
	Addicted	65.8	16.7	15.8	1.8	114		
They'll have a better life	Nonaddicted	1.2	1.2	32.6	65.1	86	1.95	NS
	Addicted	0.9	4.4	28.9	65.8	114		
They'll drop out of school	Nonaddicted	61.6	22.1	11.6	4.7	86	11.42	< 0.01
	Addicted	43	24.6	29.8	2.6	114		
They'll get a good job	Nonaddicted	2.4	3.5	27.1	67.1	85	2.91	NS
	Addicted	1.8	7.1	34.5	56.6	113		
They'll wind up in jail	Nonaddicted	74.1	14.1	7.1	4.7	85	13.75	< 0.01
	Addicted	50.9	21.1	23.7	4.4	114		
They'll become drug addicts	Nonaddicted	76.5	10.6	10.6	2.4	85	16.7	< 0.001
	Addicted	47.8	22.1	23.9	6.2	113		
They'll get a good education	Nonaddicted	2.3	0	14	83.7	86	4.34	NS
	Addicted	0.9	0.9	23.7	74.6	114		

TABLE 12.--Social supports reported available for child care (in percent)[1]

Support question	Nonaddicted (N)	Addicted (N)
Is there anyone in your life who makes raising your child easier for you?	92.9 (85)	90.1 (111)
Is there anyone in your life who makes raising your child much harder for you?	37.6 (85)	48.6 (111)
Do you get as much help from other people in raising your children as you would like?	75 (84)	77.3 (110)
Is there anyone that you really trust to take good care of your children?	98.8 (86)	96.4 (111)

[1]Percent responding "yes."

TABLE 13.--Person trusted to take good care of child (in percent)

Person mentioned	Nonaddicted	Addicted
Respondent's partner/child's father	34.1	17.8
Respondent's mother	42.4	59.8
Relative other than parents	43.5	50.5
Friend	14.1	8.4
Paid help	2.4	0.9

Note: Columns total more than 100 percent because more than one response was allowed.

$p < 0.05$). Less than 15 percent of the addicted women reported themselves able to turn to their drug treatment centers as resources or even as places to talk about problems with children.

Table 14 shows that more of the addicted women with children in this sample lived with their mothers than did the nonaddicted women with children (χ^2 (4) = 12.42; $p < 0.05$). This suggests that maternal grandmothers may be the primary, or at least a major, source of support in childrearing. It is interesting to note that the addicted women with children were as likely as the childless addicted women to live with their mothers. However, this was not true for the nonaddicted women. The nonaddicted mothers were much less likely to live with their mothers than the childless nonaddicts (χ^2 (4) = 28.43; $p < 0.0001$).

Timing of Births in Relation to Drug Use

The literature on children of addicts appears to assume that the children were all born to women who were already heroin users. As already noted, the literature is focused on pregnant addicts, physical consequences for fetuses and neonates, and women who are heroin users during pregnancy. However, there is no reason to assume that the child of a woman who is presently addicted was born to that woman after she became a heroin user. It is just as reasonable to assume that many women begin using heroin after the birth of a child rather than before.

TABLE 14.--Location of respondent's mother (in percent)

Where mother lives	Nonaddicted		Addicted	
	Mothers (N=87)	Non-mothers (N=88)	Mothers (N=117)	Non-mothers (N=50)
With respondent	11.5	45.5	26.5	26
In respondent's neighborhood	14.9	3.4	17.1	8
In respondent's city	27.6	14.8	29.1	18
Elsewhere	31	23.9	22.2	34
Not alive	14.9	12.5	5.1	14

The interview schedule did not include a direct question about whether or not the respondents were addicted when their children were born. However, the information can be obtained by comparing the age of the woman when her first child was born with her age when she first tried heroin (both of which questions were posed). Since there may have been a long lapse between first use and more regular or addictive use, a similar approach can be taken with the question, "How old were you when you began using drugs regularly?" Responses to this question do not necessarily refer to heroin use. Although these questions do not provide precisely the information we are seeking, the responses give a good sense of whether it was possible that a woman was addicted or using heroin regularly when the first child was born.

Less than one-third (31 percent) of the women had even tried heroin before their first child was born. Within a year of the birth of the first child, 14.3 percent of the women tried heroin for the first time. Over one-half (54.7 percent) of the addicted mothers did not try heroin until the year after their first child was born.

The data also indicate that 37.9 percent of the mothers tried heroin for the first time within 2 years after the birth of their first child, and similarly, 30.2 percent of the mothers tried heroin for the first time within 2 years of the birth of their youngest child. (Recall that "only" children are counted as both oldest and youngest child.) The timing may be largely coincidental. As a young troubled woman reaches the age when she is likely to have children, she is also more likely to be in situations in which she is exposed to heroin. However, having a young child may be one additional stress that may tip her toward heroin use.

The data remind us that many children of heroin-addicted mothers were not born as addicted babies. The problems of addicted fetuses and neonates and the effects of addiction on the mother-infant relationship (e.g., Coppolillo 1975; Finnegan 1976; Parke and Collmer 1975) may not be problems for these children and their mothers. We are not suggesting that these children's lives are easy or unworthy of the attention of treatment programs. On the contrary, we are suggesting that at least some of the attention and resources should be directed toward addicted women and their children and not only toward fetuses and neonates.

Our earlier work (NIDA 1979) has shown that addicted women face many social difficulties, some of which are clearly a consequence, rather than a cause, of their addiction. Children of addicted mothers may also suffer, not necessarily at the hands of their mothers, but because their mothers are heroin addicts confronted both with vanishing material and social resources and with the rejection and disdain of others.

In this connection, it is interesting to note that many heroin-addicted males have fathered children and many continue to live with them. Heroin and its attendant problems are also a part of the lives of these children, and their mothers or other caretakers (frequently grandmothers) are likely to be as stressed as the caretakers of the children of addicted women or as the addicted women themselves. Yet, the children of addicted males have not been a focus of concern.

We see here a problem that seems to have cropped up for many women, not just heroin-abusing women. Gomberg (1979) has noted an analogous and even more striking situation in the response to the fetal alcohol

syndrome. Although the majority of alcoholic women are past their childbearing years (even if they are of an age to be able to have children), the recent emphasis has been on the babies of alcoholic women. Women have been blamed and have been made to feel guilty about their actions affecting future generations. Thus, substance abuse takes on moral overtones for women but not necessarily for men. Colten (1978) has reported that men and women addicts overwhelmingly agree that women addicts are looked down on more than men addicts, and the women addicts have so internalized this assessment of themselves that they believe that women addicts are worse than men addicts.

SUMMARY AND DISCUSSION

The data show that addicted women want children for reasons that do not differ substantially from those of other women of similar socioeconomic status. In most respects, they do the same kinds of things with their children. They are less strict, less physically punitive, and more likely to feel inadequate and have greater fears about the future of their children. They are also more likely to feel that parents may not have as much control as outside sources have.

It is clear from the data that research and treatment programs may have been overly concerned with the physical effects on the child of the use of heroin by the mother, when in fact many children of addicted mothers were not exposed to heroin in utero. Further, many of the children, even if they were subject to the physical effects, are no longer infants, and at this point the social aspects of having an addicted mother may be the most important for them and their mothers. Thus, while it is important for programs to be concerned with the health and well-being of fetuses and neonates, prenatal medical attention and the teaching of tenets of basic infant care are clearly not sufficient and will not meet the present needs of many of these women and their children.

A theme that runs through the data is that a substantial minority of addicted women feel that they are not good mothers (about one of five women in treatment) and that even more feel concern at times about childrearing issues far less troublesome to nonaddicted mothers--issues of whether or not their child(ren) might drop out of school, end up in jail, or become involved with heroin. The literature indicates that the general premise of many treatment programs is that addicted women are bad mothers. When programs do provide assistance with the mothering role to women, the programs appear to take the approach that addicted mothers have inherent psychological deficits that prevent them from being adequate mothers.

This could well be a self-fulfilling prophecy. If addicted mothers are treated as if they are inept, guilty, and irresponsible, then they will tend to feel and, possibly, behave that way. It is hard to be a good or even a "normal" or average mother when all around you let you know that they think you are unable to be.

It will be important for all treatment programs to attend properly to those women clients with child responsibilities with a focus on their roles as mothers. The program must recognize the centrality of that role to the client. Over half of the women in this sample said that their children were the most important things in their lives.

In this regard, it has been reported that many mothers avoid seeking treatment because programs do not make provisions for children. Others may avoid treatment because of fears that once it is known that they are addicts they will be forced to relinquish their children. An evident first step for programs is to allay these fears, and, if the mother does have custody of the child, programs should either provide or help the mother to get quality daycare for younger children. Treatment programing should be carefully scheduled to simplify the life of the mother and child so that the mother can be available to see older children off to school and can have someone there when they return, so that she need not choose between the program and her mothering responsibilities. Scheduling difficulties, while seemingly trivial, loom large for many parents.

Over 73 percent of the women reported that they had had worries about their children's health in the past month and 30 percent reported having had childrearing problems. Recall that only a small percentage of these women even spoke to someone at their treatment programs about these problems. It is quite evident that resources should be made available at programs to help women handle these issues. It should be recognized that the women may be afraid to ask for help since any admission of problems may constitute further proof of their inadequacy. The mothers must be allowed and encourged to seek assistance and be made aware that the problems and worries they experience with their children are common to all mothers. Further, while being addicted may compound the problem, it is neither the cause of the difficulties nor an overwhelming barrier to their solution.

Thus, based on the data, it is suggested that services should be provided for both mothers and children, service that runs the gamut from daycare and medical and counseling services to parenting workshops and scheduled recreational outings. In the process of teaching women to take control of their own lives, programs should also teach mothers that they can have substantial positive impact on the lives of their children. Some programs are already attempting these services, although it is not yet clear to what extent these programs are able to provide the comprehensive services required.

The mothers of these addict-clients appear to provide a substantial portion of the support for childrearing. While this is critical and much needed, it may be too great a burden for many individuals, who have additional responsibilities of their own. It is important for the women to expand their bases of support--to have more people to rely upon for assistance and support. Treatment programs could certainly encourage interdependence and reciprocity between the women in the program and also teach them to create, and use, other supports.

Others have written compellingly about the need for special services for women with children. These data remind us that the services are necessary. Even more importantly, they tell us that the services must take on a very special cast--they must recognize the centrality of the relationship between mother and child and must be nonjudgmental and nonpunitive toward the mothers. The data suggest that while some childrearing concerns are large for a number of these addicted mothers, most of their behaviors and attitudes differ little from those of their nonaddicted peers.

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Children of Addicts and Nonaddicts
A Comparative Investigation in Five Urban Sites

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Abstract

This investigation was conducted in five urban areas to determine whether 3- to 18-year-old children living with heroin-dependent parents are at greater risk for health, learning, behavioral, socioemotional, and/or adjustment problems than are 3- to 18-year-old children living with nonaddict parents in the same neighborhoods.

The randomly selected parent/child groups represented 160 addict (Index) families and 160 nonaddict (Comparison) families. As part of the test battery the Stanford-Binet Intelligence Scale vocabulary subtest and the Peabody Picture Vocabulary Test were administered to 3- to 7-year-olds ($\underline{N}$=34 in each group); the 8- to 18-year-olds ($\underline{N}$=126 in each group) and all other respondents were interviewed. Additional data were collected from schools, community agencies, and the drug treatment programs attended by Index parents.

It was found that the groups differed on relatively few items. There was little or no difference between groups in terms of--

- Parents' childrearing practices and methods of discipline;
- Parental expectations of their children;
- Children's attitudes about school, and parents' perceptions of how well children were doing in school;
- Reports of abuse or neglect;
- Reports of ever using cigarettes; and
- Reports of ever using alcohol.

Data for this report were gathered by Opinion Research Corporation (Princeton, New Jersey) and Applications Research Corporation (Dayton, Ohio). Consultants on the study were Drs. Kuno Beller, Lawrence Rubin, M. Duncan Stanton, and Mr. Napoleon Turner. Major contributions were also made by Boards of Education and the following drug treatment programs: BuDA and Project Cure (Dayton), Metro East Drug Treatment Corporation (Detroit), Riverside General Hospital (Houston), Desire Narcotics Rehabilitation Center (New Orleans), Project Reality (Salt Lake City), and Weber County Mental Health Center (Ogden, Utah).

Differences did appear on--

- Scores on intelligence tests for the 3- to 7-year-olds, and
- School adjustment and behavioral problems among 8- to 18-year-olds.

It must be noted that the children of heroin addicts were significantly more likely to come from households of lower income status. This was related to higher unemployment rates and a lesser likelihood that both parents in the addicts' households would be working.

The data suggest that programs should be alert to the potential for behavioral problems of their clients' children. Where necessary, programs should be prepared to make arrangements with appropriate community agencies for services to those children.

INTRODUCTION

Most literature on the subject of children of drug abusers deals with infants born to women dependent upon heroin or methadone during pregnancy; the data suggest that these infants are indeed a high-risk group. Compared to babies in the general population, these infants show higher rates of mortality, prematurity, low birthweight, congenital defects, and other health problems. However, many of the risk factors common to addicts' infants may take months or years to affect development adversely and/or to be recognized as a problem. Research shows high correlations between poverty and high postneonatal mortality rates (Sowder 1973), between poverty and high rates of marked or severe psychiatric disorders in children (Langer et al. 1974), and between poverty and malnutrition. Malnutrition lowers a child's resistance to disease, parasitic infections, and worms; it also increases emotionality and causes delays in cognitive and psychomotor development. Both malnutrition and poverty are associated with low educational attainment (Bee 1975; Scrimshaw 1968; Sowder 1973).

Low birthweight and prematurity are also associated with learning disabilities, lower IQ scores, and other problems in older children (Nortman 1974), and lower IQ scores are reported for preschool-aged children who experienced separation from their mothers at birth (Klaus and Kennell 1976).

Child abuse and child neglect are correlated with several of these risk factors--prematurity, low birthweight, poverty, and mother-infant separation (Fanaroff et al. 1972; Klein and Stern 1971). Child abuse and neglect increase the risks of mortality and serious or permanent physical damage. Battered children may suffer emotional damage as well; they reportedly have difficulty establishing trust in others, and are fearful (Martin 1972), gloomy, unhappy, immature, and prone to antisocial behaviors (Johnson and Morse 1974). A significant correlation has been found between abuse and neglect and delinquency (Burt and Balyeat 1976), and high rates of criminal behavior are noted among abusive and neglectful parents who, themselves, often had been abused as children (Gil 1974). Many addicts report being physically abused as children (Sowder 1977), and many seem to experience emotional neglect from detached, "cold" parents (Chein et al. 1964; Fagan et al. n.d.); their later lives are often marked by delinquency (Sowder 1977) and adult criminal behaviors (Burt et al., in press). Research on the general population shows that the delinquent and adult criminal behaviors of parents are positively correlated with delinquency among their children (Ahlstrom and Havinghurst 1971; California Youth Authority 1973; Glueck and Glueck 1950; Robins and Herjanic 1975).

Five followup studies that have been conducted to determine the status of children born to addicted women (Ackerman 1976; Blinick et al. 1973; Lodge 1976; Strauss et al. 1976; Wilson et al. 1973) all focused on preschool-aged children. Except for research by Wilson and her colleagues, all these studies pertain to children born to women maintained on methadone during pregnancy.

Of these five followup studies, only two report physical problems among addicts' children. Wilson and her colleagues (1973) found unusually high rates of impaired somatic growth and questionable neurological signs among a small group of children exposed to heroin in utero. In making a comparison to several control groups, Wilson (1976) reports these children weighed less at followup, had smaller head circumferences, showed increased respiratory rates, and manifested more problems on a physical adjustment scale. Strauss et al. (1976) found a nonsignificant difference in growth measures at age 1 between 21

children of methadone-maintained mothers and children of nonaddicted mothers; the methadone group was more likely to fall below the 10th percentile on height and weight. Preliminary findings from cohort groups show similar growth lags in the methadone group. Blinick et al. (1973), however, report an absence of physical problems among 14 4-year-old children of methadone-maintained women.

Wilson (1976) also reports that young children exposed to heroin in utero scored lower than controls on a perceptual battery. Lodge (1976) reports similar findings from her longitudinal study of children born to methadone-maintained women; these children also show below average performance in fine motor skills. The methadone group studied by Strauss et al. (1976) were found to score significantly poorer than control children on the Bayley Psychomotor Development Indices (PDI), and they showed significant discrepancies between their scores on the PDI and the Bayley Mental Development Indices while controls did not.

All five followup studies show that addicts' children, as a group, score average or above on IQ tests (Ackerman 1976; Blinick et al. 1973; Lodge 1976; Strauss et al. 1976; Wilson 1976). Wilson does report that addicts' children scored lower than controls on some IQ measures but attributes this result to poor concentration and attention. Lodge also reports poor attention spans among her methadone group. She notes that language development is often above average in her sample, while Wilson reports that her group scored lower than controls on "organization skills" but not on the "receptive" or "expressive" subscales of the Illinois Test of Psycholinguistic Abilities.

Only Wilson and Lodge report on socioemotional adjustment. Wilson states that addicts' children exhibited more problems than controls on ratings of self and social adjustment scales; Lodge reports strong "oral" needs and immature play patterns among her sample but notes that these children were highly interested in people and objects. Lodge concludes that the children she studied show a "unique" pattern of development.

The limited followup findings suggest that children born to mothers dependent upon heroin or methadone may experience some growth, perceptual-motor, and socioemotional problems. However, more research is needed to clarify issues raised in the followup studies and to extend these studies to older children and larger populations and to children who were not exposed to heroin or methadone in utero, but who do live with addicted parents.

METHOD

Subjects

Five urban areas were selected for study: Dayton, Ohio; Detroit, Michigan; Houston, Texas; New Orleans, Louisiana; and Salt Lake City/Ogden, Utah. Eight large drug treatment programs in these areas provided Index subjects for this study. The universe of eligible subjects in each program was composed of all clients with a history of heroin addiction who were parents and who maintained responsibility for at least one child aged 3 to 7 (site 1) or aged 8 to 18 (sites 2 to 5) who lived with them for at least 9 months of the year. Random sampling with substitution was employed to select the participating clients. About 20 percent of the parents initially sampled refused to participate. For each parent, one target child was selected; where the parent had more than one eligible child, the selection was made randomly within the appropriate age group. The final Index sample on which this report was based was composed of 160 parents, 160 children, and 45 siblings.

The 160 Comparison parents and their children (126 8- to 18-year-olds, 34 3- to 7-year-olds, and 49 siblings) were randomly chosen from the immediate neighborhoods (1 to 4 blocks) in which Index families resided so that Index and Comparison groups would be similar in income and ethnicity. Neither Comparison parents nor their spouses[1] had experienced any problems with drugs since becoming a parent. This was determined by an initial screening of each potential Comparison subject, and a brief set of questions about knowledge of drugs that was asked of Comparison subjects. (These questions were not asked of their spouses.)

Comparison parents were selected to be equivalent to Index parents on age groups of children and family structure (one- versus two-parent households). The Comparison target children were selected randomly in the manner described earlier for the Index target children. Eleven percent of eligible Comparison parents contacted refused to participate.

More complete details on sampling, field procedures, and findings are reported in an administrative report to NIDA (Sowder and Burt 1978).

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[1] The term "spouse" refers in this report to parent-respondents' cohabitants whether or not legally married.

Instrumentation and Data Collection

Two vocabulary measures were administered to the 3- to 7-year-old target children at site 1 to assess cognitive functioning: the Peabody Picture Vocabulary Test and the vocabulary subtest of the Stanford-Binet Intelligence Scale.[2] While both instruments used assess verbal intelligence, the Peabody makes use of nonverbal stimuli, and the Stanford-Binet uses verbal cues. The two subtests formed a portion of a larger battery of tests given. Results for the nonprojective tests for which adequate norms exist are discussed in the text; results for the remaining projective tests are discussed briefly in the appendix.

The battery of tests was administered individually in 45- to 60-minute sessions by two examiners trained in clinical testing. A list of appropriate services was available for parents if testing suggested such a need.

The 8- to 18-year-old target children were interviewed by professional interviewers in 30- to 40-minute private sessions to gather information on their health, schooling, utilization of various services, interactions with family and friends, activities in the home, use of drugs and alcohol, and self-concepts.

Parents were interviewed in 30- to 45-minute sessions to obtain information about the target children's health, education, friendship patterns, and other behaviors, as well as their use of various community support services in 1976. They were asked also about childrearing practices, family structure, demographic characteristics, and drug use and treatment. In addition, information was sought from both groups regarding functioning of spouses or cohabitants.

Community agencies and schools were also included in the survey. Lists provided by drug treatment staffs and taken from directories were used to identify 169 agencies that could "validate" parents' reports of their children's utilization of various services in 1976. Agencies were mailed a list of the names of the target children at each site. They were asked to return only the number of these identified children in their 1976 caseloads. The agencies and schools were told that this was a study of problems and needs of children and families. No mention was made of the drug problems of parents. Sixty-seven percent of the agencies contacted agreed to participate.

Schools attended by 8- to 18-year-old target children were surveyed if the parents consented; 70 percent of the Index and 79 percent of the Comparison parents gave their permission. Teachers filled out a mailed questionnaire for each target child; this form asked about absenteeism, achievement, classroom behavior, popularity with other students, and service needs. Sixty-two percent of the 171 forms were returned by teachers. As with the community agencies no mention was made of the drug problems of parents. No bias was found in these data in terms of return of questionnaires. Questionnaires that were mailed first were those most likely to be returned. Nonresponse became an issue as a consequence of school closing for summer vacation.

Staff of drug treatment programs were also included in the survey. Eighty-nine percent of the Index parents gave permission for staff to complete a questionnaire concerning their treatment. Staff of drug abuse treatment programs were asked to list treatment goals and services provided individual clients and their families through a mail survey. Fifty-three percent of the 143 forms were completed by treatment staff.

Respondents were reimbursed for the time they committed to the study.

Data Analysis

Data from the standardized tests administered to the 3- to 7-year-old children at site 1 were scored using appropriate age norms for each child on each test. Interview data obtained from 8- to 18-year-old children and their parents were first analyzed by individual site using descriptive statistics and chi-square. Differences between the Index and Comparison groups were tested for statistical significance using chi-square and various parametric tests as appropriate. A significance level of 0.05 was used. Because few statistically significant differences were noted between Index groups at differing sites or between Comparison groups at differing sites, the Index groups were combined across sites as were the Comparison groups, and the statistical tests were conducted with the larger Index and Comparison groups. The "validation" data were compared to figures reported by parents for each type of service received by target children in 1976; these data are reported as ranges, where appropriate, because children may have been seen by multiple agencies for the same problem.

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[2] The correlation between the vocabulary subtest and total score on the Stanford-Binet Intelligence Scale is 0.65 for children at the sixth grade level (Terman and Merrill 1973).

Limitations

The survey was necessarily limited in some ways. For example, it does not include children under age 3, those in surrogate care, or children of heroin-addicted parents who had not entered treatment. Both geographic and ethnic representation are limited, and sample sizes are small. Much of the data represent self-reports, and validity checks were made only on selected variables. Finally, while the refusal rate was relatively low, 11 to 20 percent of the randomly selected parents did refuse to participate; consequently the samples cannot be presumed to be wholly representative of the populations from which they were drawn.

THE PARENTS

Demographic Characteristics

Over three-fourths of all the parents were black, and only small proportions of these respondents and their spouses had completed more than 12 years of schooling. Group differences on ethnicity and education were not statistically significant. More Index than Comparison parent respondents were male (41 versus 25 percent), and this sex difference was statistically significant among parents of 8- to 18-year-olds (38 versus 24 percent). Index parents were more likely than Comparison parents to be under age 31, and group differences were statistically significant for parents of 8- to 18-year-olds (53 versus 12 percent). Unemployment rates were high among these families. Seventy-one percent of all Index parents were unemployed, compared to 56 percent of all comparison parents; Index parents of 3- to 7-year-olds were significantly more likely to be unemployed than their Comparison counterparts (76 versus 47 percent). Similarly, 53 percent of all Index spouses were unemployed, compared to 29 percent of all Comparison spouses. Differences were statistically significant only for the 8-to 18-year-old study group (54 versus 27 percent).

Given these differences in employment rates and the lesser likelihood of both parents working in Index households, it was hardly surprising to find statistically significant differences between Index and Comparison groups in income levels. Most striking was the difference in the number having annual incomes below $5,000 in 1976--50 versus 19 percent of all Index and Comparison families, respectively. Of demographic differences, only income showed any statistically significant relationship to the child outcome measures, and this was limited to the Peabody scores of the 3- to 7-year-old children.

Arrests

There were substantial differences between Index and Comparison respondents with regard to arrests. The Comparison group reported few arrests for other than traffic violations since becoming parents. The Index group reported that over half (59 percent) of the parent respondents and 20 percent of their spouses had been arrested for other than traffic violations.

Drug Use

In addition to a history of heroin use, about a fourth of the Index parents of 8- to 18-year-olds also had problems with drugs other than heroin since becoming parents, and a third of the Index parents of 3- to 7-year-olds had problems with drugs other than heroin. Also, 29 percent of the 3- to 7-year-old children reportedly had been exposed to heroin in utero, and 26 percent had been exposed to other drugs in utero.

Childrearing and Family Interactions

The majority of those in all parent groups said their "spouses" helped "to raise" the children; however, older siblings were more likely to be involved in childrearing in the Comparison group. Index children were more likely than Comparison children to have extended family members (especially grandparents) involved in their upbringing. In fact, grandparents were involved in childrearing in 62 percent of all Index households compared to 21 percent of all Comparison households. These group differences were significant for the 8- to 18-year-old groups.

While there were no statistically significant differences between family groups in their reports of various childrearing practices, there was a consistent trend noted in the reports of parents and children that suggested more permissive practices among Index parents. For example, fewer Index than Comparison 8- to 18-year-olds reported that the children in their families were subject to many rules (74 versus 82 percent) and would be punished for disobeying rules (78 versus 82 percent).

By comparison, 5 percent of the 8- to 18-year-olds were reportedly exposed to heroin in utero, and 13 percent were exposed to other drugs in utero. It should be noted that

reports of mother's use of heroin and other drugs during pregnancy are not mutually exclusive. Forty-four percent used heroin and/or some other drugs during pregnancy. However, drug use during pregnancy was statistically unrelated to any of the child outcome measures.

Family Structure

The Index and Comparison groups did not differ significantly on number of parents per family since they had been "matched" on this variable; approximately 30 percent of all respondents were single parents. However, Index parent respondents were significantly less likely than their Comparison counterparts to be married (41 versus 65 percent) and more likely to be "living with someone" (29 versus 6 percent). Financial support for children in these families often differed. Male household heads provided financial support for target children in about half of the Index groups, compared to about two-thirds of the Comparison groups; the difference for the 8- to 18-year-old group was statistically significant. Grandparents, however, were more likely to be sources of financial support for Index children, and differences for 8- to 18-year-old Index and Comparison groups were statistically significant (23 versus 5 percent). Almost two-thirds of both Index groups received welfare/public assistance to support children, compared to 29 to 39 percent of the two Comparison groups; these differences were statistically significant. The groups were similar in the average number of children per family (3.3 versus 3.5 for Index and Comparison groups, respectively), and neither group had any children in foster care.

Parent groups differed little in their reported methods of discipline or in the frequency of using certain disciplinary methods. The majority of parents reported frequent use of "oral" methods of discipline (lectures, "yelling," or "threatening with a whipping"), occasional denial of privileges (e.g., watching television), and very infrequent or no use of physical punishment. Eighty percent of all parents of 3- to 7-year-olds and half of those of 8- to 18-year-olds said they "never" used physical punishment.

Significantly more Index than Comparison parents of 8- to 18-year-olds (32 versus 17 percent) reported that they spent less than 12 hours a week with their children. The difference between Index and Comparison parents of 3- to 7-year-olds (41 versus 38 percent) was not statistically significant.

A minority of Index parents reported that their drug addiction made them unable to spend enough time with their children (45 percent of those with 3- to 7-year-olds and 24 percent of those with 8- to 18-year-olds). In addition, two-thirds of the Index parents said their addiction had kept them from being the kind of parents they would have liked to be. Most stressed the financial impact of their addiction on the care provided for their children (68 percent of parents of 3- to 7-year-olds and 40 percent of parents of 8- to 18-year-olds), some said it made them unable to provide "proper care" generally (45 percent of parents of 3- to 7-year-olds and 15 percent of parents of 8- to 18-year-olds), and about one-fifth said their addiction made them "emotionally unfit" to be a parent.

Reports of 8- to 18-year-old Index children and their 3- to 7-year-old siblings did not suggest they felt any more deprived of family companionship than Comparison children. There were no statistically significant differences between the 8- to 18-year-old groups in their responses to questions about "fighting a lot" within the family (which characterized only a few); wanting to tell their parents about accomplishments or problems (as most did); engaging in such activities as shopping, watching television, or eating dinner with their families (which most did frequently); going to religious services together (as over half did); or in being separated from their families for a month or more (as occurred in about a fourth of all the families). The 8- to 18-year-old Index children were significantly less likely than their Comparison peers to say people in their families "hug and kiss a lot" (53 versus 69 percent), but significantly more likely to say that family members visited friends and relatives together often (45 versus 27 percent).

Substantial proportions of parents in both household groups wanted the target children to get married, become a good parent, make a lot of money, have a "helping career," and get an education. Education seemed to be the most valued--from 80 to 89 percent of the four parent groups wanted their children to go to college. Smaller proportions of the parents reportedly expected their children to accomplish these things.

THE CHILDREN

Age, Sex, and School Status

There were no statistically significant differences between target children on sex or school

enrollment. The Index group of 3- to 7-year-old children were younger than the Comparison group, so that substantially fewer were enrolled in school (44 versus 62 percent). The 8- to 18-year-old samples tended toward the younger age; nearly half these target children were between the ages of 8 and 10, and relatively few Index and Comparison children were aged 14 to 18 (16 and 22 percent, respectively). The few Index and Comparison children aged 8 to 18 who had dropped out of school (5 versus 2 percent) all said they planned to return and finish school.

Children and School

More than 90 percent of the 8- to 18-year-old children in both groups believed their parents wanted them to finish high school, go to college, always "do their best," and "make good grades." All parents with 3- to 7-year-old children in school and more than 90 percent of parents of 8- to 18-year-olds felt their children were doing "at least fair" in school; approximately half (from 46 to 62 percent) of the samples stated that their children were doing "very well." Approximately two-thirds of the 8- to 18-year-olds in both groups had won some honor or award during the school year, according to their parents. Index children were slightly more likely than Comparison children to win awards for sports (12 versus 8 percent) and slightly less likely to win academic awards (39 versus 46 percent).

Most parents said they visited their children's schools, and more than two-thirds of the 8- to 18-year-olds in both groups thought their parents liked their teachers. Most 8- to 18-year-old Index and Comparison children reported that they liked school "a lot" (72 percent versus 60 percent) or "some" (15 percent versus 22 percent). However, most 8- to 18-year-olds in both groups perceived themselves as being significantly further from "the center of things at school" than they wished to be. Relatively few Index and Comparison children rated themselves at the "very center" (17 percent versus 15 percent) or at an extreme distance from the center (22 versus 14 percent) of things at school, and there were no statistically significant differences between groups on any of these ratings.

Thus, the groups were alike in many respects with regard to attitudes about school and the parents' perceptions of how well their children were doing in school. There were, in fact, no statistically significant differences between groups on the above variables and little evidence in these data of any school-related problems.

Although groups did not differ significantly in their attitudes toward school, there were some indications of more school-related problems among the 8- to 18-year-old Index children. As depicted in table 1, the 8- to 18-year-old groups differed significantly in terms of disciplinary problems (teachers' reports) and receipt of special education and/or tutoring (parents' reports). Note that the teachers' reports were based on a nonrandom subsample of approximately a third of the 8- to 18-year-olds and therefore cannot be representative of the entire sample.

Nonetheless there is the suggestion that Index children are more likely than Comparison children to present discipline problems and to experience some academic problems. Regarding this latter point, it should be noted that the groups did not differ significantly in current academic standing; children in both groups were about equally divided between the upper, middle, and lower thirds of their classes in academic standing.

Cognitive Functioning of 3- to 7-Year-Olds

There were score differences within the 3- to 7-year-old groups on two of the cognitive measures used.[3] As can be seen in table 2, there was a significant difference between Index and Comparison children in mental age as measured by scores on the vocabulary subtest of the Stanford-Binet Intelligence Scale. Moreover, significantly more Index than Comparison children scored below the average score expected by established age norms on the vocabulary subtest (61 percent of Index children versus 32 percent of Comparison children). By way of contrast, there was no statistically significant difference between the scores of Index and Comparison children on the Peabody Picture Vocabulary Test. The average score of the Comparison children was 94.5, while that for the Index children was 86.7.

Many investigators have reported a statistically significant relationship between income and test performance. An important issue, in view of the significant difference in family income between the Index and Comparison groups, is the extent to which differences in these test scores can be "explained" by income. Using analysis of covariance to control for the effects of income, scores on the Stanford-

[3]For a discussion of additional tests used in the battery of instruments administered to 3- to 7-year-olds, see the appendix.

TABLE 1.--School problems of target children (percent[1])

School problem	3- to 7-year-olds		8- to 18-year-olds	
	Index	Comparison	Index	Comparison
Absenteeism (parents' reports)				
Child ill/parent kept home	87	76	84	80
Child skipped/didn't want to go[2]	13	5	18	6
Child told not to come by school staff[2]	7	5	5	3
Parent contacted by school for absences[2]	7 (N=15)	- (N=21)	17 (N=120)	9 (N=123)
Missed 6 or more days (teachers' reports)	NA[3]	NA[3]	66 (N=46)	45 (N=49)
Behavior problems				
Parent contacted by school for child's behavior (parents' reports)	21 (N=15)	5 (N=21)	31 (N=120)	19 (N=123)
Needs discipline (teachers' reports)	NA	NA	[4]71 (N=40)	[4]45 (N=41)
Child doesn't obey teacher (teachers' reports)	NA	NA	[5]49 (N=39)	[5]11 (N=44)
Child doesn't work well in groups (teachers' reports)	NA	NA	54 (N=39)	34 (N=44)
Child destructive of school property[2] (teachers' reports)	NA	NA	15 (N=39)	4 (N=44)
Received counseling for fighting[2,6] (8- to 18-year-old reports)	NA	NA	32 (N=34)	19 (N=23)
Received tutoring special education (parents' reports)	[2]7 (N=15)	[2]13 (N=21)	[4]35 (N=120)	[4]23 (N=123)
Repeated grades[2] (teachers' reports)	NA	NA	24 (N=45)	7 (N=46)
Received counseling (parents' reports, site 1; 8- to 18-year-old reports, sites 2-5)	[2]16 (N=15)	[2]3 (N=21)	28 (N=120)	19 (N=123)

[1]Figures rounded.
[2]Small cell sizes prohibited statistical testing.
[3]Not asked for a group.
[4]Significant @ 0.05.
[5]Significant @ 0.001.
[6]Includes only those who received some type of counseling in school.

TABLE 2.--Children's performance on different tests

	Index t-test (N=33)	Comparison t-test (N=34)	Significance p
Peabody Vocabulary (Group mean score)	86.7	94.5	--
Stanford-Binet Vocabulary Subtest			
Chronological age	4.5	5.3	0.01
Mental age[1]	3.4	6.2	0.05

[1]Mental age is based on test norms (adjusted for the chronological age of each child).

Binet vocabulary subtest still discriminated between groups (with the significance level changed from 0.01 to 0.05).

Physical and Mental Health Status

Investigation was made of the health status of target children at birth and at the time of study, as well as of children's use of medical facilities (e.g., emergency rooms, physicians, and dentists).

Thirteen percent of all 8- to 18-year-olds required medical attention at birth, as did 29 percent of the 3- to 7-year-old Index children and 9 percent of the 3- to 7-year-old Comparison children. Requiring medical services at birth significantly discriminated ($p < 0.05$) between the 3- to 7-year-old Index and Comparison groups. Health problems at birth for all groups included prematurity, respiratory disorders, allergies, jaundice, and hernia; drug addiction at birth was, of course, reported only for the Index groups (12 and 15 percent for 8- to 18-year-olds and 3- to 7-year-olds, respectively). There were no statistically significant differences between Index and Comparison children in terms of their utilization of emergency rooms or physicians in 1976. In that year, 31 percent of all Index children and 27 percent of all Comparison children paid at least one visit to an emergency room; respective figures for one or more physician visits for an accident or illness were 51 versus 44 percent, while figures for physician visits for a "checkup only" were 65 versus 61 percent.

According to parents, no 3- to 7-year-old child had ever received mental health services. Confirming these reports, the large mental health center serving the neighborhoods in which the children resided had no record of any of these children in its 1976 caseload. For 8- to 18-year-olds, one Index parent and two Comparison parents reported use of mental health services from a "mental health center, a child guidance clinic, or a psychiatric clinic" in 1976. Seventeen percent Index and 2 percent Comparison 8- to 18-year-olds reported themselves to be currently receiving mental health services. According to community validation data, 2 percent of Index and 5 percent of Comparison children were reported to have received mental health services in 1976. There were no statistically significant differences in the number of Index and Comparison children perceived by teachers to be in need of family counseling (37 percent versus 26 percent) or in reports by 8- to 18-year-olds of receipt of school counseling services (28 percent versus 19 percent), although significantly more Index than Comparison children were seen by teachers to be in need of individual counseling (46 percent versus 26 percent). Whether or not any knowledge of parents' status may have influenced teacher perceptions is unknown.

There were few statistically significant differences between the 8- to 18-year-old groups in their responses to a number of questions designed to tap their feelings about "self" and "others." Most of these Index and Comparison target children said they felt good about themselves "almost all of the time" (85 versus 83 percent). It is noteworthy that 47 to 55 percent of the 8- to 18-year-old Index children consistently rated themselves as "much better" than others their own age on such things as sports, being well dressed, being good looking, having teachers like them,

having many friends their own age, and being able to defend themselves. On these same statements, Comparison children were more likely to rate themselves as "a little better" than others their own age. Few children in either group rated themselves in the "worse than others" category. Although these group differences were not statistically significant, they may suggest either that Index children think more highly of themselves than Comparison children or that they wish to leave the impression of being considerably better at many things than their peers.

The Index group was significantly more likely than the Comparison group to answer "false" to the statement "When I get into trouble, it's usually my own fault" (46 versus 30 percent) and true to the statement "I think good luck is more important than hard work for success" (44 versus 33 percent). This might suggest a belief in or use of an external locus of control (Rotter 1966), i.e., control lying outside the self. Since adult addicts have been found to score high on measures denoting an external locus of control (e.g., DeLeon 1974; Obitz and Oziel 1973), it is possible that the Index children have acquired this orientation from their parents.

Children and Their Friends

According to the parents, most target children had a number of friends, and these friends visited their homes frequently. Comparison parents were more likely than Index parents to say they did not disapprove of any of their children's friends; the respective figures were 85 versus 56 percent for 3- to 7-year-olds and 62 versus 40 percent for 8- to 18-year-olds. The group differences for 8- to 18-year-olds were statistically significant.

According to parents, only a few children in each group "hung around the streets" with their friends when the friends visited their homes; the majority spent much of their time watching television or playing games. Among 8- to 18-year-olds, 48 percent of the Index and 40 percent of the Comparison children engaged in sports with their friends; the corresponding figures for the 3- to 7-year-old groups were 33 versus 64 percent, and this difference was statistically significant. Further, 29 percent of 3- to 7-year-old Index children but no Comparison children were reported as playing alone rather than with friends most of the time. It should be recalled that 3- to 7-year-old Index children were significantly younger than the 3- to 7-year-old Comparison children and less likely to be of school age; this fact may have influenced that finding.

In contrast to data from self-reports and parents' reports, the teachers of 8- to 18-year-olds reported more Index than Comparison children to be "below average in popularity with other students" (33 percent versus 17 percent); this difference was statistically significant.

Abuse and Neglect

Abuse and neglect was not a principal focus of this investigation. Therefore, relatively few questions were asked on this subject. Table 3 presents abuse/neglect data that were obtained from parents and the community validation survey.

Small cell sizes prohibited statistical testing of the data shown in table 3. However, there are obviously no substantial group differences, although Index parents of 8 to 18-year-olds were more likely than Comparison parents to report abuse or neglect as "ever" occurring. Parent reports regarding 8- to 18-year-olds tend to correspond to teacher reports but are at marked variance with those data available from other community sources. The latter suggests no differences between Index and Comparison groups; these data, of course, are limited to 1976. Several factors should be considered in interpreting the data. First, it is generally believed that most abuse and neglect cases are not reported to official agencies; thus the percentages of recorded cases indicated in table 3 probably understate the actual prevalence of abuse and neglect. Second, all community agencies did not return the community validation forms; therefore, the percentages of cases actually recorded could be higher than indicated in the table. Also, it is noteworthy that both Index and Comparison parents underreported the fact that their children's names were recorded as abuse or neglect cases by the courts, the police, or social service agencies in 1976.

Running Away From Home

The official definition of runaway child is one who is away from home overnight without permission. Two (6 percent) of the 3- to 7-year-old Index children were runaways by this definition. Both children, according to their parents, had run away from home twice at age 3. Among 8- to 18-year-olds, eight Index (6 percent) and four Comparison (3 percent) parents stated that their child had run away from home at least once; the mean number of runaway episodes was 2.2 and 2.4 for the Index and Comparison children, respectively.

TABLE 3.--Reports of abuse/neglect (A/N) (percent[1])

Name recorded for A/N--1976	Site 1		Sites 2 to 5	
	Index	Comparison	Index	Comparison
Parents	3 (N=34)	3 (N=34)	2 (N=126)	2 (N=126)
Community validation	[2]--	[3]12-18	[3]9-14	[3]11-14
Abuse "ever" occurred (parents' reports)	9 (N=34)	3 (N=34)	13 (N=126)	3 (N=126)
Neglect "ever" occurred (parents' reported)	12 (N=34)	3 (N=34)	19 (N=126)	4 (N=126)
Need protective services (teachers' reports)	NA	NA	15 (N=46)	4 (N=49)

[1]Figures rounded.
[2]Only five Index parent respondents at site 1 consented to having names of target children sent to agencies; one of the five target children had been recorded as a victim of abuse/neglect in 1976.
[3]The lower number is based on the assumption that all agencies in the community reported on the same children; the higher number is based on the assumption that all agencies reported on different children. Because individual names were not reported to the research team, one can be confident only that the true number lies somewhere in this range.

Delinquent Behavior Among the 8- to 18-Year-Olds

Table 4 shows the different types of information gathered on behaviors usually classified as delinquent. The data were gathered only on children in the 8- to 18-year-old groups.

Eighteen percent of both Index and Comparison 8- to 18-year-olds reported having been in trouble with the police at some time. Among these youths, there were somewhat more encounters involving the Index than the Comparison group ($\bar{X}$=2.3 versus $\bar{X}$=1.3), as reported by the youths themselves. Ten percent of Index parents compared to 2 percent of Comparison parents reported their children had "ever" been picked up by the police. The community validation data suggest that about as many Comparison as Index children appeared before the court or were on probation in 1976. Since some courts did not respond to the inquiries, it is possible that the Index group's delinquent behavior was underreported by courts; nonetheless, the data suggest that Comparison parents underreported their children's problem behaviors.

In addition to the above, 4 percent (5 of 126) of the 8- to 18-year-old Index children (but no Comparison children) said they engaged in work "for pay" that could get them "in trouble with police." Interestingly, Index children were significantly less likely than Comparison children to respond "true" to the statement, "policemen are well thought of in my family" (46 percent versus 63 percent). In addition, 8- to 18-year-old Index children were more likely than their Comparison peers to report they got into a "lot of fights" (19 versus 10 percent), although this difference was not statistically significant.

Substance-Taking Behavior Among the 8- to 18-Year-Olds

Data on the use of cigarettes, alcohol, and other drugs were collected for the 8- to 18-year-olds. (See table 5.) There were no statistically significant differences between

TABLE 4.--Delinquency among the 8- to 18-year-olds (percent[1])

Problem	Index	Comparison
Ever been in trouble with the police? (Reports of 8- to 18-year-olds)		
Yes	18	18
No	75	80
Don't know/refused to answer	7	2
	(N=67)	(N=66)
Ever picked up by the police? (Parents' reports)		
Yes	10	2
No	90	98
	(N=126)	(N=126)
Child appeared in juvenile court before 1976? (Parents' reports)[2]		
For delinquency	5	2
Found to be delinquent	2	--
	(N=126)	(N=126)
Child appeared in juvenile court in 1976? (Parents' reports)[2]		
For delinquency	3	1
On probation	3	1
	(N=126)	(N=126)
Child appeared in juvenile court for delinquency or on probation? (Community validation)[2,3]	1	3
	(N=126)	(N=126)

[1]Figures rounded.
[2]Small cell sizes prohibited statistical testing.
[3]Community validation survey incomplete.

groups in their use of cigarettes. Twenty-three percent of the 126 Index children stated that they had "ever" smoked compared to 17 percent of their Comparison peers; however, Comparison youngsters were likely to indicate heavier smoking.

Approximately the same number of youngsters in each group indicated that they had "ever" used alcohol. None reported drinking any more frequently than twice weekly. Parents gave similar answers regarding the children's use of alcohol.

Parent respondents did not indicate that any of the 14- to 18-year-old children had received alcohol treatment in 1976; the community validation survey suggests that six (37 percent) of the 14- to 18-year-old Index children but no Comparison children had received alcohol abuse treatment in 1976. (Sample sizes are 16 Index and 22 Comparison 14- to 18-year-olds.)

Among the Index children (8 percent) and Comparison children (4 percent) who reported having "ever" used drugs without a prescription (table 5), 60 percent of each group (9 of 15 youths total) said that marijuana was the only drug they had ever tried. Eight drug categories were used in the questionnaire, including an "other drug" category. Only Index youngsters (N=5) reported ever having had a "bad trip" or feeling "bad" after taking drugs. When asked whether their 14- to 18-year-old children had received drug treatment services in 1976, all 22 Comparison parents said "no," while 3 (19 percent) of

TABLE 8.--Substance-taking behaviors of target children (percent[1])

Behavior	Index	Comparison
Cigarette smoking		
Smokes now		
Yes	6	8
No	94	92
	(N=126)	(N=126)
Frequency of smoking (by children who smoke now)		
Tried only a few times	66	48
Less than once a day	7	10
1 to 11 a day	24	33
More than 11 a day	--	10
Don't know	3	--
	(N=29)	(N=21)
Drinking		
Drinks now		
Yes	9	5
No	91	95
	(N=11)	(N=6)
Frequency of use (by children who ever used)		
Tried a few times	65	85
Once or twice a week	21	11
More than 1 ot 2 times a week	--	--
Don't know/no response	14	4
	(N=29)	(N=27)
Received alcohol abuse treatment in 1976[2]		
Patient's responses	--	--
Community validation	[3]37	--
	(N=16)	(N=22)
Drugs		
Ever used marijuana or other drugs		
Yes	8	4
No	89	95
Don't know/refused to answer	3	1
	(N=126)	(N=126)
Received drug abuse treatment in 1976[2]		
Parents' responses	19	--
Community validation	[3]31	[3]14
	(N=16)	(N=22)

[1]Figures rounded; small cell sizes prohibited statistical testing of most data in the table.
[2]Responses limited to information on 14- to 18-year-olds.
[3]Five of the six cases were reported from one site.

the 16 Index parents said "yes." The community validation forms returned on the 14- to 18-year-olds again suggested underreporting by parents; these figures showed that 31 and 14 percent of these Index and Comparison youngsters, respectively, were included in drug abuse treatment center caseloads in 1976. There is obvious inconsistency between the reports of alcohol and drug use by the youthful respondents and the reports from community agencies on alcohol and drug abuse treatment for 1976. The basis for the reported high rate of treatment relative to reported substance use is not known.

SUMMARY AND DISCUSSION

Children of heroin-dependent parents differed from comparison-group children in few areas. Differences which were statistically significant appeared on--

- Scores on intelligence tests for 3- to 7-year-olds, and
- School adjustment and behavioral problems among 8- to 18-year-olds.

There were little or no differences between groups in terms of--

- Parents' childrearing practices and methods of discipline,
- Childrens' attitudes about school and parents' perceptions of how well children were doing in school,
- Reports by community agencies of abuse or neglect,
- Self-reports of ever using cigarettes, and
- Self-reports of ever using alcohol.

In general, the data presented here suggest that a number of the children of heroin-addicted parents live in multiproblem families and that those families may benefit from services that are infrequently available in drug abuse treatment programs. Under current mandate, most federally funded drug treatment programs can assist children of addicts by providing referral services and/or including these children in family counseling sessions. Although several of the programs that participated in this survey do provide some family services, most treatment programs do not offer a comprehensive array of those services.

It is possible that with proper intervention some of the problems noted among these children could be mitigated. The 8- to 18-year-old Index children appear in general to have positive self-images and positive perceptions of their own interactions with their families. The Index families studied appear to have a number of strengths that could be drawn upon in any intervention process. These parents have high hopes and expectations for their children's future. Education, in particular seems to be valued by these parents and their children. Assisting parents as appropriate to enhance their children's educational achievement (e.g., linking them with tutoring services) may be one means of involving them in further efforts to aid their children.

At a minimum, clinics should be alert to the potential problems of their clients' offspring and should consider making arrangements with appropriate community agencies for care of the children.

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APPENDIX

The vocabulary subtest of the Stanford-Binet Intelligence Test and the Peabody Picture Vocabulary Test were given to 3- to 7-year-olds in one program site as part of a larger test battery that included the Bender-Gestalt Test and the Draw A Person Test, where the latter was used to assess both intelligence and socioemotional functioning. Inasmuch as the Stanford-Binet and the Peabody were the only nonprojective tests used, their results are the only ones reported in the main text.

Statistically significant differences were obtained between groups for Bender-Gestalt drawings using age norms developed on very young children at Maimonides Community Mental Health Center in New York City. In this comparison, the Index children were found to display a lower level of perceptual motor functioning than the Comparison group.

Significant differences between groups based on the Draw A Person IQ were not obtained after controlling for the effect of income. While judges' blind ratings of socioemotional functioning based on human figure drawings yielded significant differences favoring the Comparison children, it should be kept in mind that whatever its value as a part of a clinical battery of tests, the facts that children's drawings have been found to vary from one testing to the next and that validity of the instrument for personality ratings has never been established render the Draw A Person an unsatisfactory research instrument.

Conclusions

The two studies reported in this monograph speak to the similarities in parenting practices between addicted parents and their nondrug-using peers. Indeed, not only are parents' activities in relation to their children similar in both groups, but the functioning of same-aged offspring in drug- and nondrug-abusing groups is generally quite similar as well. Thus, addicted parents and nondrug-using parents of youngsters have the same expectations and wishes with regard to their children's futures; the two groups make like demands on their children and have similar disciplinary practices. Children of addicted and nondrug-using parents have comparable attitudes about school and show equivalent levels of academic performance; they also report similar, and low, levels of substance use. Parents of both groups report similar levels of parental neglect/ abuse.

While similarities predominate, the reports do highlight selected issues that commend themselves to the attention of drug abuse treatment staff. Thus, while parenting practices differ little between addict-parents and their nondrug-using counterparts, a substantial minority of addict-parents evidence intense concern and felt inadequacy in their performance of the parenting role. Similarly, addicted parents voice concern that their offspring may experience the kinds of difficulties that have characterized the parents' own lifestyles, e.g., criminal activities, drug abuse, and the like. Clearly, there is a need on the part of drug treatment programs to make available counseling/training in parenting skills and/or supportive counseling around the parenting role. Again, it is not so much that there are marked differences between addicted parents and nondrug-using parents, it is simply that a number of addicted parents are intensely concerned about their capability to fulfill a role that they view as immensely important to their sense of self and to their effective functioning in the community.

In addition, it must be recognized that some minority of offspring of addicted clients do, in fact, show evidence of behavioral problems and of difficulties in school adjustment. These youngsters may not only profit from program efforts to grant parents the opportunity to acquire greater parenting skills and confidence in those skills, but can benefit from some remedial action tied more directly to the youngsters' own functioning. Specifically, it would seem appropriate for the drug abuse program to consider the functioning of the drug abuse client's family. Where problems are detected, the drug abuse program can undertake elements of family counseling/ therapy. If resources to provide this service are lacking, the program should endeavor to make referrals to appropriate community service agencies and to coordinate whatever service functions are needed in an effort to guarantee that the client and her or his family receive appropriate attention.